GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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GAMMIS Batch Health Care Encounter Claims

837D (004010 X097A1) - Dental

837I (004010 X096A1) - Institutional

837P (004010 X098A1) - Professional

Companion Guide

Georgia Medicaid Management Information System
Fiscal Agent Services Project

Version 1.7

Disclaimer: The information contained in this Companion Guide is subject to change. EDI submitters are advised to check the Provider Pre-Readiness site http://providerinfo.mmis.georgia.gov/providerprereadiness/home.aspx) regularly for the latest updates before and after go-live.

Document Control

Modification Log

Version #	Date	Modified By	Change/Update Details
0.1	12/28/009	Kim White	Creation of document – 1st Draft.
0.2	12/22/2009	Elaine Selfridge	Updated per GAMMIS standards.
0.3	12/31/2009	Elaine Selfridge	Updated as a result of DCH feedback.
0.4	01/12/2010	Kim White	Updates made based on review with DCH and CMOs.
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1.1	02/18/2010	Kim White	Removed all references to 835. Section 5 – Modified last sentence and NOTE. 2010BB-NM103: Changed to GEORGIA MEDICAID. All CN101's: Modified verbiage. Section 1.2 #2: Modified to include Provider Tax ID. 837I: Removed all references to '0B' – State License Number
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1.3	03/18/2010	Elaine Selfridge	Disclaimer added to title page. Section 5 revised.
1.4	04/1/2010	Kim White	837P: 2010BB – NM103 changed to GEORGIA MEDICAID.
1.5	05/13/2010	Kim White	Modified Section 2.1 (File/System Specifications) to reflect file extension requirement.
1.6	07/22/2010	Kim White	Based on CMO weekly meeting, removed DTP01-DTP03, where DTP01=471 from the 837P section of the CG.
1.7	08/26/2010	Kim White	Section 2 and 3: Added website information Section 5: Added contact information

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Owner	HP Enterprise Services GAMMIS PMO
Author	Frank Martin (frank.martin@hp.com)
Approved By	
Approval Date	

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1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the *Final Rule for Standards for Electronic Transactions* can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

1.1 Purpose

The 837 transaction is used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic Dental, Institutional and Professional claim submissions to the Georgia Department of Community Health (DCH). The intent is to expedite the goal of achieving a totally electronic data interchange environment for health care encounter/claims processing, payment, corrections, and reversals. This transaction will support the submission of Dental, Institutional and Professional claims and encounters.

- Georgia Department of Community Health only allows the submission of encounters on the 837 transactions.

All required segments within the 837 transactions must always be sent by the submitter and received by the payer. Optional information will be sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments in the incoming transaction may not be used during claims processing, some of these data elements will be returned in other transactions such as the Unsolicited Claim Status (277 Transaction Set).

1.2 Special Considerations for 837 Transactions

1. Subscriber, Insured = Member in the Georgia Medicaid Eligibility Verification System

The Georgia Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/recipients are primary subscribers within each.

2. Provider Identification = Georgia Medicaid ID or NPI

The implementation date for National Provider Identifier (NPI) was May 23, 2007.

Beginning May 23, 2008 for all health care providers, the Provider NPI, Provider Tax ID, Taxonomy Code and ZIP Code + four-digit postal code must be received in the appropriate loops. The NPI will be sent in the NM109, where NM108 equals XX, the Provider Tax ID will be sent in the REF02, where REF01=EI. The Taxonomy Code will be sent in the PRV03 and the ZIP Code + four-digit postal code will be sent in the N403 and N404.

For all non-healthcare providers where an NPI is not assigned, the claim must contain the Medicaid Provider Number within the appropriate loops within the REF segment where REF01 equals 1D.

3. Logical File Structure:

There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE) however; the functional groups must be the same type.

4. Submitter:

Submissions by non-approved trading partners will be rejected.

5. Acknowledgement Transaction (824 Application Reporting)

A response transaction will be returned to the trading partner that is present within the ISA06 data element.

The Georgia Department of Community Health will provide an 824 Application Reporting Acknowledgment for all transactions that are received.

You will receive this acknowledgment within 48 hours unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for a request type transaction, i.e. 270 or 276, you will receive the appropriate response transaction generated from the request. If the transaction submitted was a claim transaction, i.e. 837, you will receive the 824 and the unsolicited 277 if the 837 passed compliance.

Note: The unsolicited 277 is provided daily.

6. When NM108 = 24 or REF01=EI:

If the NM108 equals 24 (Employer Identification Number (EIN)) or the REF01 equals EI (EIN) within any loop, the value in the corresponding NM109 or REF02 must be in the format of XX-XXXXXXX.

Note: This format includes the hyphen (-).

7. Claims Allowed per Transaction (ST/SE envelope):

The HIPAA implementation guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments.

The Georgia Department of Community Health does not have a maximum for the number of claims per transaction (ST/SE envelope); however the file size must not exceed 50mb.

8. Document Level:

For Encounters the Georgia Department of Community Health processes files at the batch level. Which means if one compliance error is received in the file, the entire file will be rejected and reported on the 824 transaction.

9. Dependent Loop:

The Georgia Department of Community Health, the subscriber is always the same as the patient (dependent). Claims containing data in the Patient Hierarchical Level (2000C loop) may not process correctly.

10. Compliance Checking:

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. In addition to Level 4, Level 7 patient (dependent) level will occur if 2000C patient loop is received. All other levels will be validated within the GAMMIS.

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2 Transmission and Data Retrieval Methods

HP Enterprise Services supports several types of data transport depending upon the provider's, or trading partner's needs. Trading Partners will submit and receive data using Secure File Transfer Protocol (SFTP).

1. Secure File Transfer Protocol (SFTP): SFTP uses Secure Shell (SSH) to encrypt and then securely transmit data across a potentially unsecured connection. Functionally SFTP (required) is similar to FTP, but offers protection to sensitive data. Secure Shell or SSH is a network protocol that allows data to be exchanged using a secure channel between two networked devices.

   HP Enterprise Services requires that the SFTP submitters send their public key and HP Enterprise Services exchanges its public key with the submitter for encryption purposes. HP Enterprise Services will setup a username and password for the submitter to access the server.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at: www.mmis.georgia.gov.

2.1 File/System Specifications

EDI will only accept Windows\PC\DOS formatted files.

EDI will allow upload and download of zipped or compressed files.

EDI requires file extensions. Preferred extension is .dat, however other extensions such as .txt, .edi, .txn are allowed.

Note: Only one X12 transaction file is permitted in each "zipped" file. Any file size that is 5MB or larger is required to be zipped or compressed.

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3 Testing

In order to submit claims, a provider or their representative or billing agent must be authorized. The authorization process requires the submission of the Electronic Data Interchange Agreement, issuance of a trading partner ID, and testing to assure the trading partner can accurately submit transactions.

The trading partner certifies their transactions through EDIFECS Ramp Manager. The Ramp Manager product is a free self-service, Web-based testing tool for X12 transactions. It includes a number of support utilities for submitting, troubleshooting, and testing X12 files. The intent is to certify that an entity can successfully submit a compliant X12 file.

More information about testing procedures is located on the Provider Public Web site at: www.mmis.georgia.gov.

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4 Transmission Responses

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), a Application Reporting transaction (824), and an Unsolicited Claim Status (277U).

Once a transaction is received, it will go through a 'front end' compliance check called a TA1. The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the 'front end' compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction will receive an Application Reporting Transaction (824) to provide feedback on the transaction. The 824 contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contains no syntactical errors, a positive 824 response will be generated and the transaction is passed on for processing.

Once the 837 transaction is accepted within EDI the 837 transaction is translated and processed. An X12 version 3070 – 277U will be generated daily once the translated file has processed. The 277U transaction will contain accepted and rejected encounter claims. If the encounter claim was rejected a value of "REJECTED" will be present within the 2200D-REF02, where REF01=1K. If the encounter claim was accepted a 13-digit ICN will be present.

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5 EDI Support

The HP Enterprise Services EDI Service Team is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software
3. Provide assistance to billing agents, clearinghouses and software vendors
4. Identifying and troubleshooting technical issues
5. Data Exchange help

The EDI staff will be available Monday through Friday 8:00 a.m. to 5:00 p.m. EST by calling 877-261-8785 or 770-325-9590.

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6 Control Segment Definitions for Georgia Medicaid 837D, 837I and 837P encounter claim Transactions

X12N EDI Control Segments
ISA – Interchange Control Header Segment
IEA – Interchange Control Trailer Segment
GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header
SE – Transaction Set Trailer
TA1 – Interchange Acknowledgement

6.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

837 Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.3	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
B.3	N/A	ISA	ISA02 - Authorization Information	[space fill]
B.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
B.4	N/A	ISA	ISA04 - Security Information	[space fill]
B.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.4	N/A	ISA	ISA06 - Interchange Sender ID	'Trading Partner ID' Supplied by Georgia Medicaid left justified and space filled. *The Trading Partner ID, will be the same Trading Partner ID used in current system.*
B.4	N/A	ISA	ISA07 - Interchange ID	'ZZ' – Mutually Defined

837 Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Qualifier	
B.5	N/A	ISA	ISA08 - Interchange Receiver ID	**'77034'** – GA MMIS Trading Partner ID. Left justified and space filled. ***Note:*** *Current system this value was 100000.*
B.5	N/A	ISA	ISA09 - Interchange Date	The date format is YYMMDD.
B.5	N/A	ISA	ISA10 - Interchange Time	The time format is HHMM
B.5	N/A	ISA	ISA11 - Interchange Control Standards Identifier	'U' – Interchange Control Standards Identifier
B.5	N/A	ISA	ISA12 - Interchange Control Version Number	'00401' – Control Version Number
B.5	N/A	ISA	ISA13 - Interchange Control Number	Interchange Unique Control Number – Must be identical to the interchange trailer IEA02
B.6	N/A	ISA	ISA14 - Acknowledgment Request	'0' – No Acknowledgement Requested '1' – Acknowledgement Requested – HP Enterprise Services will return an 824 Application Reporting transaction.
B.6	N/A	ISA	ISA15 - Usage Indicator	'T' - Test Data 'P' - Production Data
B.6	N/A	ISA	ISA16 - Component Element Separator	':' – Component Element Separator

6.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

837 Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.7	N/A	IEA	IEA01 - Number of included Functional Groups	Number of included Functional Groups
B.7	N/A	IEA	IEA02 - Interchange Control Number	Must be identical to the value in ISA13

6.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

837 Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.8	N/A	GS	GS01 - Functional ID Code	'HC' – Health Care Claim (837)
B.8	N/A	GS	GS02 - Application Sender's Code	This will be equal to the value in ISA06.
B.8	N/A	GS	GS03 - Application Receiver's Code	This will be equal to the value in ISA08.
B.8	N/A	GS	GS04 - Date	The date format is CCYYMMDD
B.8	N/A	GS	GS05 - Time	The time format is HHMM
B.9	N/A	GS	GS06 - Group Control Number	Group Control Number
B.9	N/A	GS	GS07 - Responsible Agency Code	'X' – Responsible Agency Code
B.9	N/A	GS	GS08 - Version/ Release/ Industry ID Code	'004010X097A1' – Version / Release / Industry Identifier Code

6.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

837 Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.10	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
B.10	N/A	GE	GE02 – Group Control Number	Must be identical to the value in GS06

6.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

837 Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
53	N/A	ST	ST01 – Transaction Set Identifier Code	'837' – Health Care Claim
53	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number

6.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
313	N/A	SE	SE01 – Number of Included Segments	Total Number of Segments included in Transaction Set including ST and SE.

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
313	N/A	SE	SE02 – Transaction Set Control Number	Must be identical to the value in ST02

6.7 TA1 – Interchange Acknowledgement

The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

837 Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.11	N/A	TA1	TA101 - Interchange Control Number	Interchange control number of the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA102 - Interchange Date	The date format is YYMMDD Date within the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA103 - Interchange Time	The time format is HHMM Time within the original interchange received (ISA/IEA)
B.12	N/A	TA1	TA104 - Interchange Acknowledgement Code	'A' – Transmitted interchange control structure header/trailer received without errors. 'E' – Transmitted interchange control structure header/trailer received and accepted, errors are noted. 'R' – Transmitted interchange control structure header/trailer rejected due to errors.
B.12	N/A	TA1	TA105 - Interchange Note Code	See 837D Implementation Guide for valid values.

6.8 Valid Delimiters

The following delimiters must be used for the 837 Encounter Claim Transactions for Georgia Medicaid otherwise the transaction may not process correctly.

Definition	**ASCII**	**Decimal**	**Hexadecimal**
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

7 Companion Guide for the Encounter 837D Transaction

This section specifies X12 837D fields for which Georgia Medicaid has specific requirements.

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Header				
55	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
56	N/A	BHT	BHT06 - Transaction Type Code	'RP' – Reporting
Submitter Name				
61	1000A	NM1	NM109 - Identification Code	'CMO Regional Medicaid Provider ID'
Receiver Name				
67	1000B	NM1	NM103 – Name Last or Organization Name	'GEORGIA FAMILIES'
67	1000B	NM1	NM109 - Identification Code	'77034' - Georgia Medicaid Payer ID
Billing Provider Name				
71	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider
72	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
72	2000A	PRV	PRV03 - Provider Specialty Code	Provider Taxonomy Code
78	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
78	2010AA	NM1	NM109 - Identification	If NM108='XX' (NPI)

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Code	If NM108='24' (EIN) If NM108='34' (SSN)
82	2010AA	N4	N403 - Zip Code	Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks)
2010AA Billing Provider REF Segment After May 23, 2008, REF01=1D, where REF02=Medicaid Provider Number should only be sent if the billing provider is not required to have a National Provider Identifier.				
84	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01='1D' should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D'
84	2010AA	REF	REF02 - Reference Identification	If REF01='EI' (EIN) If REF01='SY' (SSN) If REF01='1D' (Georgia Medicaid Provider ID) See comments on associated REF01
Subscriber Level For Georgia Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the member and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.				
97	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure
99	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	'S' – Secondary **(Primary COB)** 'T' – Tertiary **(Secondary COB)**

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
101	2000B	SBR	SBR09 - Claim Filing Indicator Code	'MC' - Medicaid
Subscriber Name				
104	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
105	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
106	2010BA	NM1	NM109 - Identification Code	Georgia Member Medicaid Number
Payer Name				
118	2010BB	NM1	NM103 - Name Last or Organization Name	'GEORGIA MEDICAID'
118	2010BB	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
118	2010BB	NM1	NM109 - Identification Code	'77034' - Georgia Medicaid Payer ID
Claim Information				
150	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Control Number GF is requiring a concatenated field for the CLM01 element. This will allow maximum usage of this element to carry multiple information segments inside the single element. These sub-elements will not be separated by the ":", but merely concatenated together. Although this format is not required by the Implementation Guide, it will be required by GF for correct processing and evaluation of the encounter. See next fields for CLM01

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				specifications.
150	2300	CLM	CLM01 – Position 1	The Media Type will be the first byte of the CLM01 element in the X12 837 transaction. **P** - Paper **E** - Electronic **W** - Web **I** - IVR **R** - Portal
150	2300	CLM	CLM01 – Position 2	The Claim Status will be the second byte of the CLM01 element in the X12 837 transaction. **P** - Paid **D** - Denied
150	2300	CLM	CLM01 – Position 3-38	Submitter's Claim Identifier CMO Claim number combined with Providers Patient Control Number.
151-152	2300	CLM	CLM05-1 – Facility Type Code	Enter the two-digit Place of Service (POS) code at the claim header. *Note if the POS is not received at the detail, the header POS will be copied.
151-152	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value indicates whether the current claim is an original claim, a void, or an adjustment. Valid values are as follows: 1 = Original Claim 7 = Adjustment (Replacement of Paid Claim) 8 = Void (Credit only).

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				The ICN to Credit should be placed in the 2300-REF02, where REF01='F8'. Providers must use the most recently paid ICN when voiding or adjusting a claim.
157	2300	DTP	DTP01 – Date Time Qualifier	'435' – Admission
157	2300	DTP	DTP02 – Date Time Period Format Qualifier	'D8' - CCYYMMDD
157	2300	DTP	DTP03 – Service Date	Admission date expressed as CCYYMMDD **Required on inpatient visit claims.**
162	2300	DTP	DTP01 – Date Time Qualifier	'452' – Appliance Placement
162	2300	DTP	DTP02 – Date Time Period Format Qualifier	'D8' - CCYYMMDD
163	2300	DTP	DTP03 – Service Date	Date of orthodontic appliance placement expressed as CCYYMMDD. **Required to report the date orthodontic appliances were placed.**
164	2300	DTP	DTP01 – Date Time Qualifier	'472' – Service This DTP Segment is Required if all of the services on the claim was performed. (i.e. If 2300-CLM19='PB' is not present)
164-165	2300	DTP	DTP02 – Date Time Period Format Qualifier	'D8' - CCYYMMDD
165	2300	DTP	DTP03 – Service Date	Date of Service
180	2300	REF	REF01 – Reference	'F8' – Original Reference

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Identification Qualifier	Number
180	2300	REF	REF02 - Reference Identification	Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credit/voided). Required if resubmitting a previously accepted encounter. Used in case for replacement.
IG 182/ October 2002 Addenda 17	2300	REF	REF01 - Reference Identification Qualifier	'G1' – Prior Authorization Number '9F' – Referral Number
IG 182/ October 2002 Addenda 17	2300	REF	REF02 - Reference Identification	If, REF01=G1, REF02 =Prior Authorization Number If, REF01=9F, REF02 = Referral Number
Referring Provider Name				
189	2310A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
189	2310A	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
199	2310A	PRV	PRV03 - Provider Specialty Code	Referring Provider Taxonomy Code (used for claims submitted

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				with NPI)
193-194	2310A	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated NM109 data element and the REF01=1D should not be used. Non-healthcare providers must send this REF segment where REF01='1D'
194	2310A	REF	REF02 - Reference Identification	If REF01='1D' (Georgia Medicaid Provider ID) See comments on associated REF01
Rendering Provider Name				
197	2310B	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
197	2310B	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
199	2310B	PRV	PRV03 - Reference Identification	Rendering Provider Taxonomy Code (used for claims submitted with NPI)
201-202	2310B	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated NM109 data element and the REF01='1D' should not be used. Non-healthcare providers must send this REF segment where REF01='1D'
202	2310B	REF	REF02 - Reference Identification	If REF01='1D' (Georgia Medicaid Provider ID) See comments on associated REF01.
Other Subscriber Information The 2320 Other Subscriber Information loop can occur up to ten times for up to 10 payers. CMO COB information will always be Primary and **required** in order for pricing to work effectively where SBR01=P (Primary)				
210	2320	SBR	SBR01 - Payer Responsibility Sequence Number	'P' – Primary (**Always CMO**) 'S' – Secondary (**Primary COB**) 'T' – Tertiary (**Secondary COB**) CMO COB information will always be Primary and **required** in order for pricing to work effectively. This is also true for the corresponding segment occurrences associated with the Primary COB/CMO iteration.
210	2320	SBR	SBR02 – Relationship Code	'18' – Self (CMO) For all other relationships, please reference Implementation Guide for Valid Values.
211	2320	SBR	SBR09 – Claim Filing Indicator Code	'MC' – Medicaid (CMO) Please reference

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				Implementation Guide for additional Valid Values.
213-219	2320	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed. Use "225" for interest. Any interest paid for the claim should be reported in a CAS segment. Note: Do not report interest paid as a separate line item on the encounter record.
220	2320	AMT	AMT01 - Amount Qualifier Code	'D' – Payer Amount Paid
220	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (CMO Amount Paid when Primary, otherwise Amount paid per COB). It is acceptable to show "0" amount paid.
222	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
222	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Allowed Amount Paid (CMO Allowed Amount when Primary, otherwise Allowed Amount per COB).
Other Subscriber Name				
233	2330A	NM1	NM108 – Identification Code Qualifier	**'MI' -** Member Identification Number
233	2330A	NM1	NM109 – Identification Code	Member ID
Other Payer Name				
241	2330B	NM1	NM109 – Identification Code	This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				payer. Georgia Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02. Note: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail.
246	2330B	DTP	DTP01 - Date Claim Paid	'573' - Other Payer Claim Adjudication Date
246	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
246	2330B	DTP	DTP03 – Date Time Period	Adjudication Date or Date claim was received by CMO.
248	2330B	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
249	2330B	REF	REF02 - Reference Identification	CMO ICN/TCN
Line Counter				
265	2400	LX	LX01 – Line Counter	Georgia Medicaid will accept up to the HIPAA allowed 50 detail lines per claim. Increment each Service Line counter by one (1).
268-269	2400	SV3	SV304-1 - Oral Cavity Designation	Enter the appropriate Mouth Quadrant code for each procedure. Only the first value listed for each procedure will be used to process the claim. Enter data in the Oral Cavity Designation Code or the Tooth Code/

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				Number and Tooth Surface, but not both.
272	2400	TOO	TOO02 - Industry Code	Enter the appropriate 2-digit Tooth Number on the line item for each procedure. Each line should contain only one Tooth Number (for permanent teeth) or Tooth Character (for primary teeth). Refer to the National Standards Tooth Numbering System for the appropriate Tooth Number or Tooth Letter for the procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
272	2400	TOO	TOO03-1 - Tooth Surface Code	Enter the appropriate Tooth Surface code for each procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
273	2400	DTP	DTP01 – Date Time Qualifier	'472' – Service This DTP Segment is Required if Dates of Service are different than those submitted within the 2300-DTP03, where DTP01=472.
273	2400	DTP	DTP02 – Date Time Period Format Qualifier	'D8' - CCYYMMDD
274	2400	DTP	DTP03 – Service Date	Service Date
275	2400	DTP	DTP01 – Date Time	'441' – Prior Placement.

837 Dental Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Qualifier	
275	2400	DTP	DTP02 – Date Time Period Format Qualifier	'D8' - CCYYMMDD
276	2400	DTP	DTP03 – Service Date	Prior Placement date expressed as CCYYMMDD. If, the SV305 data element = "R - Replacement" the Prior Placement date is required.
Line Adjudication Information				
302	2430	SVD	SVD01 – Identification Code	This number must match one occurrence of the 2330B-NM109 identifying Other Payer
302	2430	SVD	SVD02 – Service Line Paid Amount	Service Line Paid Amount
305-311	2430	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
312	2430	DTP	DTP01 - Date Claim Paid	'573' - Service Paid Date
312	2430	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
312	2430	DTP	DTP03 – Date Time Period	Adjudication Date or CMO Paid Date

8 Companion Guide for the Encounter 837I Transaction

This section specifies X12 837I fields for which Georgia Medicaid has specific requirements.

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Header				
58	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
59	N/A	BHT	BHT06 - Transaction Type Code	'RP' – Reporting
Submitter Name				
63	1000A	NM1	NM109 - Identification Code	'CMO Regional Medicaid Provider ID'
Receiver Name				
68	1000B	NM1	NM103 – Name Last or Organization Name	'GEORGIA FAMILIES'
68	1000B	NM1	NM109 - Identification Code	'77034' - Georgia Medicaid Payer ID
Billing Provider Name				
71	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider
72	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
72	2000A	PRV	PRV03 - Provider Specialty Code	'Provider Taxonomy Code'
77	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
78	2010AA	NM1	NM109 -	If NM108='XX' (NPI)

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Identification Code	If NM108='24' (EIN) If NM108='34' (SSN)
81	2010AA	N4	N403 - Zip Code	Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks)
2010AA Billing Provider REF Segment After May 23, 2008, REF01=1D, where REF02=Medicaid Provider Number should only be sent if the billing provider is not required to have a National Provider Identifier.				
83-84	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01=1D should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-Healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D'
84	2010AA	REF	REF02 - Reference Identification	If, REF01=EI (EIN) If, REF01=SY (SSN) If, REF01=1D (Georgia Medicaid Provider ID) See comments on associated REF01
Subscriber Level For Georgia Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the member and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.				
100	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure
102	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	'S' – Secondary **(Primary COB)** 'T' – Tertiary **(Secondary COB)**
104-105	2000B	SBR	SBR09 - Claim Filing	'MC' - Medicaid

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Indicator Code	
Subscriber Name				
109	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
110	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
110	2010BA	NM1	NM109 - Identification Code	Georgia Member Medicaid Number
Payer Name				
127	2010BC	NM1	NM103 - Name Last or Organization Name	'GEORGIA FAMILIES'
127	2010BC	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
128	2010BC	NM1	NM109 - Identification Code	'77034' - Georgia Medicaid Payer ID
Claim Information				
158	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Control Number GF is requiring a concatenated field for the CLM01 element. This will allow maximum usage of this element to carry multiple information segments inside the single element. These sub-elements will not be separated by the ":", but merely concatenated together. Although this format is not required by the Implementation Guide, it will be required by GF for correct processing and evaluation of the encounter. See next fields for CLM01 specifications.
158	2300	CLM	CLM01 – Position 1	The Media Type will be the first

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				byte of the CLM01 element in the X12 837 transaction. **P** - Paper **E** - Electronic **W** - Web **I** - IVR **R** - Portal
158	2300	CLM	CLM01 – Position 2	The Claim Status will be the second byte of the CLM01 element in the X12 837 transaction. **P** - Paid **D** - Denied
158	2300	CLM	CLM01 – Position 3-38	Submitter's Claim Identifier CMO Claim number combined with Providers Patient Control Number.
159	2300	CLM	CLM05-1 - Facility Type Code	Value received is the 1st two positions of the Type of Bill (TOB).
159-160	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value received is the 3rd position of the Type of Bill (TOB). Frequency Code also indicates whether the current claim is an original claim, a void, or an adjustment. Valid values are as follows: 1 = Original Claim 7 = Adjustment (Replacement of Paid Claim) 8 = Void (Credit only). The ICN to credit should be placed in the 2300-REF02 where REF01='F8'. Providers must use the most recently paid ICN when voiding or adjusting a claim.
165	2300	DTP	DTP01 - Date/Time	'096' – Discharge

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Qualifier	Specifying type of date or time or both date and time. (required for inpatient)
165	2300	DTP	DTP02 – Date Time Period Format Qualifier	'TM' – Time (HHMM)
166	2300	DTP	DTP03 - Date Time Period	Discharge Hour
167	2300	DTP	DTP01 - Date/Time Qualifier	'434' – Statement Covers Period Dates
167	2300	DTP	DTP02 - Date Time Period Qualifier	'D8' - Date Expressed in Format CCYYMMDD 'RD8' – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
168	2300	DTP	DTP03 - Date Time Period	Statement From / Through Date. If, a single date is received, it is assumed from / through dates equal.
176	2300	CN1	CN101 – Contract Type Code	'05' – Capitated Use this segment if the rendering provider is Capitated by the CMO. CLM02 should be a value of zero. The paid amounts by line item should be zero.
191	2300	REF	REF01 – Reference Identification Qualifier	'F8' – Original Reference Number
192	2300	REF	REF02 – Reference Identification	Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credit/voided). Required if resubmitting a previously accepted encounter. Used in case for replacement.
Note: For those HI Segments Page 232 thru Page 299 within the 837I Implementation Guide that can repeat multiple times and allow up to 12 occurrences of information within each segment all will				

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
be captured and stored within the MMIS.				
Principle, Admitting, E-Code Diagnosis				
227	2300	HI	HI01-1 - Qualifier Code	'BK' – Principal ICD9 Diagnosis
228	2300	HI	HI01-2 – Industry Code	ICD9 Diagnosis Code
228	2300	HI	HI02-1 - Qualifier Code	'BJ' – Admitting ICD9 Diagnosis
228	2300	HI	HI02-2 – Industry Code	ICD9 Admitting Diagnosis Code
229	2300	HI	HI03-1 - Qualifier Code	'BN' – E-Code / Injury Related
229	2300	HI	HI03-2 – Industry Code	ICD9 E Diagnosis Code
Diagnosis Related Group (DRG)				
230	2300	HI	HI01-1 - Qualifier Code	'DR' – DRG
230	2300	HI	HI01-2 – Industry Code	DRG – Required if Inpatient Claims were paid using DRG
Other Diagnosis Information				
232	2300	HI	HI01-1 - Qualifier Code	'BF' – Other ICD9 Diagnosis
233	2300	HI	HI01-2 – Industry Code	Additional ICD9 Diagnosis Code. Other Diagnosis Codes that co-exist with the principal diagnosis co-exist at the time of admission or develops subsequently during member's treatment. The 837I allows for 2 Other Diagnosis Information segments for a total of 24 other diagnosis codes per claim.
Principle Procedure Information				
242	2300	HI	HI01-1 - Qualifier	'BP' – Common Procedural

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Code	Health Care Financing Administration Coding System Principal Procedure 'BR' – International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure
243	2300	HI	HI01-2 – Industry Code	Principal Procedure Code
243	2300	HI	HI01-3 – Date Time Period Format Qualifier	'D8' – Date Qualifier (CCYYMMDD) Use only if HI01-1='BR'
243	2300	HI	HI01-4 – Date Time Period	Procedure Date
Other Procedure Information				
244	2300	HI	HI01-1 - Qualifier Code	'BO' – HCPCS/CPT Code 'BQ' – ICD9 Surg Proc Code
244	2300	HI	HI01-2 – Industry Code	Other Procedure Codes CPT Procedure Codes ICD9-CM
245	2300	HI	HI01-3 – Date Time Period Format Qualifier	'D8' – Date Qualifier (CCYYMMDD)
245	2300	HI	HI01-4 – Date Time Period	Other Procedure Date
Value Code Information (BIRTH WEIGHT) *Required when Admission Type Code 2300-CL101='4' (Newborn)				
280	2300	HI	HI01-1 - Qualifier Code	'BE' – Newborn Birth Weight
281	2300	HI	HI01-2 – Industry Code	'54' + Newborn Weight in Grams
Note: For those HI Segments Page 232 thru Page 299 within the 837I Implementation Guide that can repeat multiple times and allow up to 12 occurrences of information within each segment all will be captured and stored within the MMIS.				

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Attending Physician Name **Note:** Required for Inpatient Services				
323	2310A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
323	2310A	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
324	2310A	PRV	PRV01 - Provider Code	'AT' – Attending
325	2310A	PRV	PRV03 - Provider Specialty Code	Attending Provider Taxonomy Code Used for claims submitted with NPI
326-327	2310A	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Beginning on May 23, 2008, Healthcare providers must begin sending NPI in the associated NM109 data element and the REF01='1D' should not be used. Non-healthcare providers may send this REF segment where REF01='1D'.
327	2310A	REF	REF02 - Reference Identification	If REF01='1D' (Georgia Medicaid Provider ID) Note: The Medicaid Provider Number should only be sent if the attending physician is not required to have a National Provider Identifier.

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Other Provider Name				
337	2310C	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
337	2310C	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
340-341	2310C	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Beginning on May 23, 2008, Healthcare providers must begin sending NPI in the associated NM109 data element and the REF01=1D should not be used. Non-healthcare providers may send this REF segment where REF01='1D'
341	2310C	REF	REF02 - Reference Identification	If REF01='1D' (Georgia Medicaid Provider ID) Note: The Medicaid Provider Number should only be sent if the performing provider is not required to have a National Provider Identifier.
Service Facility Name				
350	2310E	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				'34' – Social Security Number for non-healthcare provider
350	2310E	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
356	2310E	N4	N403 – Zip Code	Service Facility Provider Zip Code + 4 postal code (excluding punctuation and blanks)
357-358	2310E	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Beginning on May 23, 2008, Healthcare providers must begin sending NPI in the associated NM109 data element and the REF01=1D should not be used. Non-healthcare providers may send this REF segment where REF01='1D'.
358	2310E	REF	REF02 - Reference Identification	Note: The Medicaid Provider Number should only be sent if the Service Facility Provider is not required to have a National Provider Identifier.
Other Subscriber Information				
360	2320	SBR	SBR01 - Payer Responsibility Sequence Number Code	'P' – Primary (**Always CMO**) 'S' – Secondary (**Primary COB**) 'T' – Tertiary (**Secondary COB**) CMO COB information will always be Primary and **required** in order for pricing to work effectively. This is also true for the corresponding segment occurrences associated with the Primary COB/CMO iteration.
361	2320	SBR	SBR02 – Relationship Code	'18' – Self (CMO) For all other relationships,

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				please reference Implementation Guide for Valid Values.
363-364	2320	SBR	SBR09 - Claim Filing Indicator Code	'MC' – Medicaid (CMO) Please reference Implementation Guide for additional Valid Values.
367-370	2320	CAS	CAS02, CAS05, CAS08, CAS 11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed. Use "225" for interest. Any interest paid for the claim should be reported in a CAS segment. Note: Do not report interest paid as a separate line item on the encounter record.
371	2320	AMT	AMT01 - Amount Qualifier Code	'C4' – Payer Amount Paid
371	2320	AMT	AMT02 - Payer Paid Amount	CMO Amount Paid when Primary. Otherwise Amount Paid per COB. It is acceptable to show "0" amount paid.
372	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
372	2320	AMT	AMT02 - Payer Paid Amount	CMO Allowed Amount when Primary. Otherwise Allowed Amount per COB.
Other Subscriber Name				
402	2330A	NM1	NM108 – Identification Code Qualifier	**'MI' -** Member Identification Number
403	2330A	NM1	NM109 – Identification Code	Member ID
Other Payer Name				
411	2330B	NM1	NM109 – Identification Code	This number must be identical to at least once occurrence of the 2430-SVD01 to identify the

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				other payer. Georgia Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02. Note: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail.
415	2330B	DTP	DTP01 - Date/Time Qualifier	'573' - Other Payer Claim Adjudication Date
415	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
415	2330B	DTP	DTP03 – Date Time Period	Adjudication Date (CCYYMMDD) Date claim was received by CMO.
248	2330B	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
249	2330B	REF	REF02 - Reference Identification	CMO ICN/TCN
Service Line Number				
444	2400	LX	LX01 – Line Counter	Georgia Medicaid will accept up to the HIPAA allowed 999 detail lines per claim.
446-447	2400	SV2	SV201 – Service Line Revenue Code	
446-447	2400	SV2	SV202-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
449	2400	SV2	SV205 – Service Unit Count	Enter the number of days spent in hospital or at home. Georgia Medicaid will process only the whole number when units are entered with decimals.

837 Institutional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				Example: Units entered on the transaction 3.75 will be processed as 3 units.
Line Adjudication Information				
491	2430	SVD	SVD01 – Identification Code	This number must match one occurrence of the 2330B-NM109 identifying Other Payer
491	2430	SVD	SVD02 – Service Line Paid Amount	Service Line Paid Amount
496-500	2430	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
502	2430	DTP	DTP01 - Date/Time Qualifier	'573' - Service Paid Date
502	2430	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
502	2430	DTP	DTP03 – Date Time Period	Adjudication Date or CMO Paid Date

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9 Companion Guide for the Encounter 837P Transaction

This section specifies X12 837P fields for which Georgia Medicaid has specific requirements.

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Header				
64	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
65	N/A	BHT	BHT06 - Transaction Type Code	'RP' – Reporting
Submitter Name				
69	1000A	NM1	NM109 - Identification Code	'CMO Regional Medicaid Provider ID'
Receiver Name				
75	1000B	NM1	NM103 – Name Last or Organization Name	'GEORGIA FAMILIES'
75	1000B	NM1	NM109 - Identification Code	'77034' - GEORGIA Medicaid Payer ID
Billing Provider Name				
79	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider
80	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
80	2000A	PRV	PRV03 - Provider Specialty Code	'Provider Taxonomy Code'
86	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				for non-healthcare provider
86	2010AA	NM1	NM109 - Identification Code	If, NM108=XX (NPI ID) If, NM108=24 (EIN) If, NM108=34 (SSN)
89	2010AA	N4	N403 - Zip Code	Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks)
2010AA Billing Provider REF Segment After May 23, 2008, REF01=1D, where REF02=Medicaid Provider Number should only be sent if the billing provider is not required to have a National Provider Identifier.				
92	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01=1D should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-Healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D'
92	2010AA	REF	REF02 - Reference Identification	If, REF01=EI (EIN) If, REF01=SY (SSN) If, REF01=1D (Georgia Medicaid Provider ID) See comments on associated REF01
Subscriber Level For Georgia Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the member and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.				
109	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure
110	2000B	SBR	SBR01 - Payer Responsibility Sequence Number	'S' – Secondary **(Primary COB)** 'T' – Tertiary **(Secondary COB)**

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Code	
112	2000B	SBR	SBR09 - Claim Filing Indicator Code	'MC' - Medicaid
Subscriber Name				
118	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
119	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
119	2010BA	NM1	NM109 - Identification Code	'Georgia Member Medicaid Number'
Payer Name				
131	2010BB	NM1	NM103 - Name Last or Organization Name	'GEORGIA MEDICAID'
131	2010BB	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
131	2010BB	NM1	NM109 - Identification Code	'77034' - GEORGIA Medicaid Payer ID
Claim Information				
171	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Control Number GF is requiring a concatenated field for the CLM01 element. This will allow maximum usage of this element to carry multiple information segments inside the single element. These sub-elements will not be separated by the ":", but merely concatenated together. Although this format is not required by the Implementation Guide, it will be

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				required by GF for correct processing and evaluation of the encounter. See next fields for CLM01 specifications.
171	2300	CLM	CLM01 – Position 1	The Media Type will be the first byte of the CLM01 element in the X12 837 transaction. **P** - Paper **E** - Electronic **W** - Web **I** - IVR **R** - Portal
171	2300	CLM	CLM01 – Position 2	The Claim Status will be the second byte of the CLM01 element in the X12 837 transaction. **P** - Paid **D** - Denied
171	2300	CLM	CLM01 – Position 3-38	Submitter's Claim Identifier CMO Claim number combined with Providers Patient Control Number.
173	2300	CLM	CLM05-1 - Facility Type Code	Enter the 2-digit Place of Service (POS) code at the claim header. *Note if the POS is not received at the detail, the header POS will be copied to the detail for processing.
173	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value indicates whether the current claim is an original claim, a void, or an adjustment. Valid values are as follows: 1 = Original Claim 7 = Adjustment (Replacement of Paid Claim) 8 = Void (Credit only). The ICN to Credit should be

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				placed in the 2300-REF02, where REF01=F8. Providers must use the most recently paid ICN when voiding or adjusting a claim.
208	2300	DTP	DTP01 – Date Time Qualifier	'435' – Admission
208	2300	DTP	DTP02 - Date Time Period Format Qualifier	'D8' – Date (CCYYMMDD)
209	2300	DTP	DTP03 - Date Time Period	Date of admission. Required if CLM05-1 equals 21 or 51.
228	2300	REF	REF01 - Reference Identification Qualifier	'9F' – Referral 'G1' – Prior Authorization
228	2300	REF	REF02 - Reference Identification	CMO Prior Authorization Number or Referral Number
230	2300	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
230	2300	REF	REF02 - Reference Identification	Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credit/voided). Required if resubmitting a previously accepted encounter. Used in case for replacement.
Ambulance Transport Information				
249	2300	CR1	CR101 – Unit or Basis for Measurement Code	'LB'
249	2300	CR1	CR102 – Weight	Patient Weight
249	2300	CR1	CR103 – Ambulance Transport Code	Ambulance Transport Code This segment is required if CLM05-1 equals 41 or 42.

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
249	2300	CR1	CR104 – Ambulance Transport Reason Code	Ambulance Transport Reason Code **A** Patient was transported to nearest facility for care of symptoms, complaints, or both Can be used to indicate that the patient was transferred to a residential facility. **B** Patient was transported for the benefit of a preferred physician **C** Patient was transported for the nearness of family members **D** Patient was transported for the care of a specialist or for availability of specialized equipment **E** Patient Transferred to Rehabilitation Facility
250	2300	CR1	CR105 – Unit or Basis for Measurement Code	'DH' – Miles
250	2300	CR1	CR106 - Quantity	Quantity
Ambulance Certification				
257	2300	CRC	CRC01 – Code Category	'07' – Ambulance Certification The CRC segment is required if CR1 is used
258	2300	CRC	CRC02 – Certification Condition Indicator	'Y' – Yes 'N' – No CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
258	2300	CRC	CRC03 – Condition Code	**01** Patient was admitted to a hospital **02** Patient was bed confined before the ambulance service **03** Patient was bed confined after the ambulance service **04** Patient was moved by stretcher **05** Patient was unconscious or in shock **06** Patient was transported in an emergency situation **07** Patient had to be physically restrained **08** Patient had visible hemorrhaging **09** Ambulance service was medically necessary **60** Transportation Was To the Nearest Facility
EPSDT Referral				
October 2002 Addenda 37	2300	CRC	CRC01 – Code Category	'ZZ' – Mutually Defined Enter this for Health Check Referral Information.
October 2002 Addenda 38	2300	CRC	CRC02 – Certification Condition Indicator	'Y' – Yes 'N' – No Enter 'N' if no referral is made. If 'N' is entered here, enter 'NU' in 2300, CRC03

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
October 2002 Addenda 38	2300	CRC	CRC03 – Condition Code	Enter one of the following valid values: 'AV' – Patient Refused Referral 'NU' – Not Used (Patient Not Referred) 'S2' – Under Treatment 'ST' – New Services Requested
October 2002 Addenda 38	2300	CRC	CRC04 – Condition Code	Condition indicator (Use codes listed in CRC03. Required if additional condition codes are needed.)
Referring Provider Name				
283	2310A	NM1	NM101 – Identify Identifier Code	Enter 'DN' (Referring Provider)
284	2310A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
284	2310A	NM1	NM109 - Identification Code	If, NM108=XX (NPI ID) If, NM108=24 (EIN) If, NM108=34 (SSN)
286	2310A	PRV	PRV03 - Provider Specialty Code	'Referring Provider Taxonomy Code' Used for claims submitted with NPI ID
288	2310A	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Non-Healthcare providers must send this REF segment where REF01='1D'

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
289	2310A	REF	REF02 - Reference Identification	If, REF01=1D (GEORGIA Medicaid Provider ID)
Rendering Provider Name				
292	2310B	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
292	2310B	NM1	NM109 - Identification Code	If, NM108=XX (NPI ID) If, NM108=24 (EIN) If, NM108=34 (SSN)
293	2310B	PRV	PRV03 - Reference Identification	'Rendering Provider Taxonomy Code' Used for claims submitted with NPI ID
296	2310B	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Non-Healthcare providers must send this REF segment where REF01='1D'
296	2310B	REF	REF02 - Reference Identification	If, REF01=1D (GEORGIA Medicaid Provider ID)
Other Subscriber Information				
319	2320	SBR	SBR01 - Payer Responsibility Sequence Number	'P' – Primary (**Always CMO**) 'S' – Secondary (**Primary COB**) 'T' – Tertiary (**Secondary COB**) CMO COB information will always be Primary and required in order for pricing to work effectively. This is also true for the corresponding segment occurrences associated with the Primary COB/CMO iteration.

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
319	2320	SBR	SBR02 – Relationship Code	''18' – Self (CMO) For all other relationships, please reference Implementation Guide for Valid Values.
321	2320	SBR	SBR05 – Insurance Type Code	'MC' - Medicaid
321	2320	SBR	SBR09 – Claim Filing Indicator Code	'MC' – Medicaid (CMO) Please reference Implementation Guide for additional Valid Values.
327-330	2320	CAS	CAS02, CAS05, CAS08, CAS 11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed. Use "225" for interest. Any interest paid for the claim should be reported in a CAS segment. Note: Do not report interest paid as a separate line item on the encounter record.
332	2320	AMT	AMT01 - Amount Qualifier Code	'D' – Payer Amount Paid
332	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (CMO Amount Paid when Primary, otherwise Amount paid per COB). It is acceptable to show "0" amount paid.
334	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
334	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Allowed Amount Paid (CMO Allowed Amount when Primary, otherwise Allowed Amount per COB).
Other Subscriber Name				
352	2330A	NM1	NM108 – Identification Code Qualifier	**'MI' -** Member Identification Number

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
352	2330A	NM1	NM109 – Identification Code	Member ID
Other Payer Name				
361	2330B	NM1	NM109 – Identification Code	This number must be identical to at least once occurrence of the 2430-SVD01 to identify the other payer if the 2430 loop is present. Georgia Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02. Note: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail.
366	2330B	DTP	DTP01 - Date Claim Paid	'573' - Other Payer Claim Adjudication Date
366	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
367	2330B	DTP	DTP03 – Date Time Period	Adjudication Date (CCYYMMDD) Date claim was received by CMO.
369	2330B	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
369	2330B	REF	REF02 - Reference Identification	CMO ICN/TCN
Service Line				
399	2400	LX	LX01 – Line Counter	Georgia Medicaid will accept up to the HIPAA allowed 50 detail lines per claim.
401	2400	SV1	SV101-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
401	2400	SV1	SV101-2 – Procedure Code	Enter the procedure code for this service line.
403	2400	SV1	SV104 – Service Unit Count	Enter the Service Unit Count. Submit whole numbers only.
406	2400	SV1	SV109 – Emergency Indicator	Enter 'Y' if the services are known to be an emergency.
406	2400	SV1	SV111 - EPSDT Indicator	Enter 'Y' when the member was referred for services as the result of a Child Health Check-up screening.
447	2400	DTP	DTP01 - Date Claim Paid	'738' - Most Recent Hemoglobin or Hematocrit or Both '739'- Most Recent Serum Creatine
447	2400	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
448	2400	DTP	DTP03 – Date Time Period	Test Date (CCYYMMDD) Required on initial EPO claims service lines for dialysis patients where test results are being billed/reported.
466	2400	CN1	CN101 – Contract Type Code	'05' – Capitated Use this segment if the service performed by the rendering provider is capitated by the CMO. SVD02 should have a value of zero, but SVD05 should reflect the total units of service provided by line item. If the encounter contains both capitated and FFS services, the CN1 segment should be entered only for those services that are capitated.

837 Professional Health Care Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Line Adjudication Information				
555	2430	SVD	SVD01 – Identification Code	This number should match one occurrence of the 2330B-NM109 identifying Other Payer
IG 555 October 20002 Addenda 80	2430	SVD	SVD02 – Service Line Paid Amount	Service Line Paid Amount
Line Adjustment				
560-565	2430	CAS	CAS02, CAS05, CAS08, CAS 11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
566	2430	DTP	DTP01 - Date Claim Paid	'573' - Service Paid Date
566	2430	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
566	2430	DTP	DTP03 – Date Time Period	Adjudication Date or CMO Paid Date

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10 External Code Source List

Below is a list of external code source list links:

Place of Service (POS):

http://www.cms.hhs.gov/PlaceofServiceCodes/03_POSDatabase.asp#TopOfPage

Adjustment Reason Codes (External Code Source 139):

http://www.wpc-edi.com/content/view/695/1

Patient Status Code:

Please refer to the Policy Manual located – www.xxx.com.

Note: Additional external code sources references can be found in Section C of the 837 HIPAA Implementation Guides.

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